DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	01/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from January 9, 2012 through January 18, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' records and review of other documentation as indicated. The facility census the first day of the survey was 107. The Stage II sample totaled thirty-nine (39) residents.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations of staff assisting residents with their lunch meals, it was determined that the facility failed to promote the dignity of five residents (R168, R120, R15, R38, R51) while assisting with meals. Findings include: 1. On 1/9/12 Employee, E6, was assisting resident R168 with the lunch meal and was standing over the resident while feeding the resident. 2. On 1/9/12 Employee, E9, was assisting resident R120 with the lunch meal and was standing over the resident while feeding the resident. 3. On 1/9/12 Employee, E7, was assisting	F 241	**F241 DIGNITY AND RESPECT OF INDIVIDUALITY** 1. Residents R 15, 38, 51, 120, and 168 remain in the center. Staff continues to treat residents with respect and dignity during meal service. 2. In-servicing shall be held on or before March 15, 2012; for nursing staff on resident dignity during feeding. 3. Random rounds shall be completed over the next 90 days by the DON/designee to determine compliance. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allegra "Lou" NHA | TITLE: Administrator | (X6) DATE: Feb. 16, 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 resident R15 with the lunch meal and was standing over the resident while feeding the resident. 4. On 1/17/12 at 12:45 PM E7 CNA was observed feeding R38 while standing up. A second observation was made at 12:50 PM and the aide was still standing while feeding. 5. On 1/13/12 at 1:08 PM CNA E18 was observed standing while feeding R51 her lunch.	F 241		
F 247 SS=C	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interviews on 01/09/12 and 01/18/12, it was determined that the facility failed to have a formal process for notifying residents when they were receiving a room mate prior to moving the room mate into the room. Findings include: 1. On 01/09/12, R3 indicated that on a couple of occasions, she received a room mate with no notification prior to the person being admitted to her room. Interview on 01/18/12 with E11, Admissions Director, indicated that notification of residents prior to a room mate admission had no formal process and would happen occasionally. No documentation was available to indicate that residents were notified prior to having a room mate admission.	F 247	F247 RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE 1. Resident R 3 continues to reside at the center and is being treated with respect and dignity. 2. In-servicing shall be held on or before March 15, 2012; for nursing, admissions and social services staff on the formal process for notifying residents when they are receiving a room or roommate change prior to the actual event. 3. Random rounds shall be completed over the next 90 days by the Social Services Director/designee to determine compliance. 4. The SS Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/12 3/15/2012 3/15/2012 3/15/2012 ar'd agoing
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		

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F 248 SS=D	Continued From page 2 INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide activities to meet the interests as identified in the facility's assessments for one (R48) out of 39 sampled residents. Findings include: R48 was admitted to the facility with diagnoses including Parkinson's Disease, hypertension, and diabetes mellitus type II. According to the Minimum Data Set (MDS) assessment, dated 12/3/11, R48 was totally dependent on staff for all activities of daily living (ADLs) and was severely impaired for daily decision making. R48's most recent comprehensive activity assessment completed in June 2011 documented that R48 liked to spend most of her time in her room in bed and the resident enjoyed one on one (1:1) visits by staff and visitors. In addition, R48 liked to watch television (TV), reading, and listening to music. Although the assessment identified R48 liked to watch TV and listen to music, the assessment failed to ascertain the type of TV shows and/or type of music the	F 248	**F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT** 1. Resident R 48 remains in the center. The resident has been reviewed by the ICP team, and the plan of care has being revised as necessary to reflect the resident's current level of care. The resident's activity participation has been assessed to determine the residents likes and dislikes. Current residents are been audited to determine their activity preferences are identified and that residents are obtaining appropriate activity participation. 2/16/12 2. In-servicing shall be held for the activity staff on or before March 15, 2012 on resident assessment and participation in activities. 3/15/2012 3. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the Activity Director/designee. 3/15/2012 4. The Activity Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. 3/15/2012 and ongoing	

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F 248	Continued From page 3 resident enjoyed. The most recent quarterly activity assessment dated December 2011 documented that R48 participated in 1:1 programs twice a week and watched TV and listened to music. Review of R48's care plan titled "resident exhibits or is at risk for limited meaningful engagement related to social isolation, loss of control" initiated on 11/21/08 included the following goals: - resident will increase social engagement as evidenced by participation in one on one visits, small groups and unstructured involvement with peer/family/friends/staff. - resident will accept invitations to activities. Review of the November 2011 activity log titled "Resident Participation Record" revealed that R48 had four (4), 1:1 volunteer visits for the entire month and two full weeks with no activity. For December 2011, R48 had seven (7) 1:1 visits. R48 was observed daily in the AM and PM during the survey period from 1/9/12 through 1/17/12. On 1/15/12, a volunteer of the facility was observed sitting by R48's bed for a 1:1 visit. The remainder of the observation revealed R48 lying in bed with TV turned on but not on a children's cartoon station that R48 enjoyed, as reported by R48's family member during the survey. During an interview with E22 (Director of Activities) on 1/17/12 at approximately 10 AM, E22 confirmed that the above assessments failed to determine the type of TV shows and music the resident liked. Subsequent to this interview, on 1/18/12, E22 spoke with the resident and ascertained that the resident enjoyed children's	F 248	LEFT BLANK INTENTIONALLY	

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F 248	Continued From page 4 cartoons including Sponge Bob and gospel music. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 1/18/12 at approximately 2:30 PM.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	**F 272 COMPREHENSIVE ASSESSMENTS** 1. Resident R 91 has expired. Current residents are having their diagnosis checked for accuracy with the completion of their next MDS assessment. 2. In-servicing shall be completed for staff completing any section of the MDS, on accurate coding on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days on completed MDS's to determine compliance; this shall be the CRC/designee. 4. The CRC shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 272	Continued From page 5 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure one (R91) out of 30 sampled resident was assessed for a terminal diagnosis with end of life care. Findings include: 1. R91 was admitted to the facility on 11/15/11 with diagnoses which included stroke, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, total hip replacement, and dementia. The resident was on hospice (end of life) care prior to admission and continued with the same hospice contractor at this facility. The initial MDS dated 11/22/11 documented in section J1400 that the resident did not have a terminal diagnosis. An interview with the RNAC E24 on 1/17/12 confirmed that she did not think the resident had a terminal diagnosis. This resulted in there being no care plan initiated for end of life care. Review of the record revealed that although R91 was on hospice services there was not a physician documented terminal diagnosis. On 1/18/12 the contracted hospice agency	F 272	LEFT BLANK INTENTIONALLY	

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F 272	Continued From page 6 provided the documentation that R91 was terminally ill dated 10/24/11.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R15, R52 and R48) out of 39 sampled residents the facility failed to develop a care plan for an assessed need. Findings include: 1a. Cross refer F329 example # 1 R15 was administered 8 doses of PRN Ativan,	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS 1. Residents R 15, 48, and 52 remain in the center, and have been reviewed by the ICP team. Corrections have been made to their plan of care as necessary to reflect their current level of care. Current resident shall have their plan of care audited at their next scheduled care conference to ensure reflection of their level of care. 2. In-servicing shall be held on Care Planning for facility staff involved in the care plan process on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 279	Continued From page 7 an anxiety medication, during the first 11 days of January 2012. The resident did not have a care plan addressing anxiety and the approaches being used to address this condition. 1b. Cross refer F315 example # 1 R15 was admitted July 2011 totally continent of bladder. After a hospitalization in November 2011 the resident was assessed on 11/13/11 as being frequently incontinent of bladder. The facility did not develop a care plan to address R15's bladder incontinence. 2. Cross refer F329 example #2 On 12/29/11 a physician order was written for Ativan (anti-anxiety medication) 0.5 mg one by mouth every 4 hours as needed for anxiety/insomnia. Review of R52's care plans revealed the facility failed to develop a care plan addressing her anxiety and insomnia that required the use of Ativan. An interview was conducted with E15 (ADON) who confirmed the facility failed to develop a care plan with interventions addressing R52's anxiety and insomnia. 3. Cross refer F248. Review of R48's care plan titled "resident exhibits or is at risk for limited meaningful engagement related to social isolation, loss of control" initiated on 11/21/08 included the following goals: - resident will increase social engagement as evidenced by participation in one to one visits, small groups and unstructured involvement with	F 279	LEFT BLANK INTENTIONALLY	

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F 279	Continued From page 8 peer/family/friends/staff. - resident will accept invitations to activities. Although the facility developed the above care plan, the goals were not measurable. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 1/18/12 at approximately 2:30 PM.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R4, R166, R52, and	F 280	**F280 RIGHT TO PARTICIPATE IN PLANNING/CARE REVISION** 1. Residents R 4, 32, 52, and 165 remain in the center and have been reviewed by the ICP team. Corrections have been made to their plan of care as necessary to reflect their current level of care. Current resident shall have their plan of care audited at their next scheduled care conference to ensure reflection of their level of care. 2. In-servicing shall be held on Care Planning for facility staff involved in care plan process on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 280	Continued From page 9 R32) out of 39 sampled residents it was determined that the facility failed to revise the care plan to reflect the actual needs of the residents. Findings include: 1. R4's care plan dated 8/9/11 included a plan for community discharge after short term stay. An interview with R4 on 1/13/12 at 11:20 AM revealed that the resident was planning on staying at the facility long term. An interview on 1/17/12 at 10:20 AM with E15, ADON revealed the resident had initially planned on going home but had decided to stay here for now. The facility recently moved R4 from the short stay unit to the long term care area. An interview on 1/17/12 at 12:38 PM with E10, social worker revealed that about two weeks ago the resident moved to the long term care area and decided to stay here long term. Interviews with both E15 and E10 confirmed that the care plan had not been updated to reflect the new long term care plan. 2. R165 had a care plan dated 1/9/12 for prevention of deformities based on range of motion (ROM) measurements. An intervention of passive ROM to all extremities by staff for 15 minutes twice a day by nursing was included. This approach was not included in the care tasks for the aides in the electronic record. A therapy assessment dated 1/9/12 indicated contractures to left hip extension knee extension and ankle extension. The therapist did not recommend a restorative ROM program but	F 280	LEFT BLANK INTENTIONALLY	

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F 280	Continued From page 10 stated it was baseline and therapy would continue ROM. Interviews on 1/13/12 and 1/17/12 with the physical therapist E13 revealed that the care plan was initiated too soon. She stated that the therapy department was doing ROM with the other therapy services and the nursing department would not pick up this task until therapy is discontinued. She further stated that several residents' care plans would need to be reviewed due to therapy's practice of initiating the restorative nursing care plan on admission but not wanting it implemented until the resident is discharged from therapy. 3. Cross refer F315, example #2 R52 had a care plan for "Resident demonstrates capacity and motivation to improve function but exhibits or is at risk for decreasing ability to perform ADLs in: all areas listed: bathing, dressing, bed mobility, transfer, locomotion, toileting due to general weakness with interventions that include Assist resident on/off toilet with CG (contact guard) assistance." This care plan revision date was 8/29/11. Review of R52's MDS dated 12/4/11 revealed she was independent for toileting, ambulating, dressing, bed mobility, and transfers. Observations made throughout the survey revealed R52 ambulated with a rolling walker independently and toileted independently. An interview conducted with E19 (CNA) on 1/18/12 at 12:30 PM confirmed R52 was independent with her care including toileting.	F 280	LEFT BLANK INTENTIONALLY	

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F 280	Continued From page 11 On 1/18/12 at 12:50 PM an interview was conducted with E15 (ADON) who confirmed the facility failed to revise R52's care plan demonstrating her independence and improvement with her activities of daily living which included toileting. 4. Cross refer F318, example #1. Review of R32's care plan for prevention and treatment of contractures implemented on 1/22/2010 included a goal that R32 will have no increase in contractures x100 days. Interventions included measurements annually and PRN (as needed), monitor tolerance, and passive ROM (PROM) by staff to all extremities 15 minutes BID (twice a day). Although the facility conducted a care plan meeting on 9/15/11 and 12/11/11, review of the care plan meeting notes failed to identify that the resident was not receiving PROM as noted on the care plan. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 1/18/12 at approximately 2:30 PM.	F 280	LEFT BLANK INTENTIONALLY	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, it was determined that the facility failed to provide the necessary care and services pertaining to pain management for one (R96) of 39 sampled residents. R96 had experienced pain of the lower back with radiation down the left leg and the facility failed to reassess and monitor the effectiveness of R96's pain management interventions. Findings include: R96 was admitted to the facility on 4/14/08 with diagnoses including open ankle fracture, diabetes mellitus type II, heart failure, hypertension, chronic obstructive pulmonary disease, depression, insomnia, chronic pain, and sleep apnea. R96's most recent quarterly Minimum Data Set (MDS) assessment dated 12/17/11 indicated that the resident was cognitively intact for daily decision making and that he experienced pain frequently and the intensity of the pain was severe. R96's most recent pain evaluation dated 12/17/11 indicated pain locations of back, legs, and generalized. Review of R96's care plan for risk for alterations in comfort indicated that R96 will achieve an acceptable level of pain control X100 days. Interventions included: -evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. -Utilize pain scale.	F 309	**F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** 1. Resident R 96 remains in the center. The resident continues to receive effective pain management as directed by the primary care physician. Current residents have been assessed for pain and have appropriate documentation in place to reflect the assessment and effectiveness of pain and medication. 2. In-servicing shall be held for licensed nursing staff on pain assessment and management of medication effectiveness on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days to determine compliance with appropriate pain assessment and management. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 309	Continued From page 13 -Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated. -Monitor frequency of episodes of breakthrough pain to determine the need for med adjustment. The December 2011 and January 2012 Physician's Order Sheet noted an order for Tramadol (narcotic like pain medication) 50 mg. po (by mouth) every 8 hours PRN (as needed) for pain. R96 verbalized to the surveyor on 1/13/12 at 1 PM that he experiences chronic pain all over due to his health issues and rated the pain "4" on a "1-10" scale with "1" being no pain and "10" being the worst pain. R96 verbalized that his pain management goal was "4." The facility policy titled "15.6 Pain Management" stated that the purpose was "to design a plan of care to achieve an optimal balance between pain relief and preservation of function in accordance with patient directed goals." In addition, the practice standard included that: "6. Patient receiving interventions for pain will be monitored for effectiveness in providing pain relief." "6.1 Effectiveness of PRN medications is documented on the back of the MAR." Review of R96's December 2011 and January 2012 MAR (Medication Administration Record) revealed that R96 was administered Tramadol 50 mg. as needed 31 doses and 12 doses respectively. Neither the MAR or the nurses notes indicated that the nurses assessed the pain characteristics including quality, severity, and location of the pain prior to and after the administration of Tramadol.	F 309	LEFT BLANK INTENTIONALLY	

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F 309	Continued From page 14 Review of R96's December 2011 "Pain Observation and Management Flow sheet" documented for six out of the 31 administration of Tramadol 50 mg., the facility assessed and documented the pain assessment prior to and post administration. For January 2012, the facility assessed and documented pain assessment for five out of the 12 administrations of Tramadol 50 mg. Interview with E2 (Director of Nursing) on 1/18/12 at approximately 11:30 AM revealed that the expectation is that when 'as needed' pain medication is administered, the assessment of pain prior to and post medication administration was to be documented on the "Pain Observation and Management Flow sheet" and not on the back of the MAR. The surveyor requested additional evidence of pain assessment for the use of the Tramadol, however, no information was provided to the surveyor. The following pain management standards were approved by the American Geriatrics Society in April 2002 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Due to the above failures, the facility failed to objectively determine the effectiveness of the administered pain medication consistent with the	F 309	LEFT BLANK INTENTIONALLY	

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F 309	Continued From page 15 current standards of practice. This is a repeat citation from the annual survey ending 10/12/10. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 1/18/12 at approximately 2:30 PM.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R15 and R52) out of 39 sampled residents the facility failed to provide the appropriate treatment and services to maintain as much bladder continence as possible. Findings include: 1. R15 was admitted 7/20/11 with diagnoses which included congestive heart failure, hypertension and dementia.	F 315	**F315 NO CATHETER, PREVENT UTI, RESTOR BLADDER....** 1. Residents R 15 and 52 remain in the center. Both residents have had urinary incontinent assessments completed to determine a toileting plan. The residents have been reviewed by the ICP team to review the residents plan of care and updates have been made to reflect the current level of care. Current residents with urinary incontinence have been assessed for the need to a toileting plan, 3 day diary and the development of a care plan. 2. In-servicing shall be completed for licensed nurses on facility policy for Urinary Incontinence Assessment on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days to determine compliance, this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 315	Continued From page 16 Review of the 7/27/11 5 day and 7/30/11 14 day MDS assessment revealed the resident was totally continent of urine. Review of the 8/17/11 30 day and 10/14/11 90 day MDS assessment revealed the resident was now occasionally incontinent of urine. There was lack of evidence that an assessment of the change of continence was completed. R15 experienced a change of condition and was hospitalized 11/5 - 11/6/11. The return MDS assessment dated 11/13/11 indicated the resident was now frequently incontinent of urine. On 11/15/11 a urinary incontinence evaluation electronic form was completed that indicated the urinary incontinence was new and it was associated with a new onset medical condition. The facility's continence management policy documented that a three-day continence management diary would be completed. Interview on 1/17/12 with the DON E2 revealed that the form used for the three-day diary is not retained by facility but used to develop the plan of care. On 11/18/11 a urinary incontinence nursing interventions electronic form was completed that indicated the resident had mixed incontinence and the identified management program was individually selected absorbent products. This assessment did not mention the results of the three-day diary. Review of the facility's electronic documentation	F 315	LEFT BLANK INTENTIONALLY	

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F 315	Continued From page 17 for bladder continence for 11/15 - 11/18/11 revealed R15 was only incontinent of urine two out of nine shifts. However, the conclusion of the facility's assessment was to use absorbent products. No care plan was found that addressed the resident's bladder continence or incontinence. The resident's current care plan did indicate that R15 needed assistance with using the toilet. An interview on 1/13/12 at 2:45 PM with an aide who frequently cares for R15 revealed the resident is almost always continent of urine on day shift. An interview on 1/13/12 with RN E16, who completed the urinary incontinence assessment, revealed that R15 had a significant change in condition and fluctuates in her ability to be continent of urine. Review of the bladder continence documentation in the electronic record revealed; November 2011 incontinent 24 out of 90 shifts, December 2011 incontinent 22 out of 93 shifts and January 2012 incontinent 24 out of 46 shifts. Although R15 had numerous shifts in which she was continent of urine, no toileting plan was developed to restore as much bladder continence as possible. 2. The facility's policy and procedures for Continence Management documented continence status will be reviewed quarterly and with significant change as part of the nursing assessment. Practice Standards 2. If patient is	F 315	LEFT BLANK INTENTIONALLY	

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F 315	Continued From page 18 incontinent, complete a Urinary Incontinence Assessment. Address transient causes for incontinence. Initiate the Three-Day Continence Management Diary. Develop plan of care based on information from assessments and three-day continence management diary. R52 was admitted with diagnoses that included irritable bowel syndrome, hypertension, vertigo, aortic regurgitation, sick sinus syndrome, hypothyroidism, and gastroesophageal reflux disease. An MDS admission assessment dated 9/6/11 stated R52 was always continent of urine and was not on a toileting program or trial. The 12/4/11 quarterly MDS for R52 documented she was occasionally incontinent of urine and was not on a toileting program or trial. The nursing assessment completed on 12/4/11 for R52 documented no new onset of urinary incontinence. Review of R52's bladder continence documentation in the electronic record revealed; - August 28, 2011 through September 6, 2011 the CNA's documented R52 was continent of urine. -Sept 5th through the 30, 2011 incontinent 14 night shifts and once on the day shift out of 75 shifts. -October 2001 incontinent 14 night shifts and one during the evening shift out of 93 shifts. - November 2011 incontinent 16 night shifts out of 90 shifts. -December 2011 incontinent 16 night shifts and twice on the day shift out of 93 shifts. -January 2012 incontinent 2 episodes during the	F 315	LEFT BLANK INTENTIONALLY	

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F 315	Continued From page 19 day shift and 7 during the night shift out of 48 shifts. Two of these documented incontinence episodes occurred during the 7 day look back period for the 12/4/11 quarterly MDS assessment. Although the MDS dated 12/4/11 documented R52 was occasionally incontinent of urine the facility failed to have documentation that a Urinary Incontinence Assessment was completed to address causes and initiate a three-day continence diary. There was no evidence that programs were put in place to help restore and maintain R52's bladder function. During an interview with E15 (ADON) on 1/17/12 at 2:20 PM confirmed a thorough assessment was not completed, a 3-day dairy was not completed nor was a toileting program to maintain bladder function for R52 initiated. E15 continued to state she was not aware of R52's incontinent episodes.	F 315	LEFT BLANK INTENTIONALLY	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of other documentation as indicated and interview, it was determined that the facility failed to ensure	F 318		

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F 318	Continued From page 20 that two (R32 and R15) out of 39 sampled residents with a limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. The facility failed to ensure that the passive range of motion was provided twice a day to R32 and once a day for R15 who had contractures. Findings include: 1. R32 was admitted to the facility in 2009. Diagnoses included chronic airway obstruction, diabetes mellitus type II, hypertension, atrial fibrillation, and tachycardia. R32's care plan for prevention and treatment of contractures implemented on 1/22/2010 included a goal that R32 will have no increase in contractures x100 days. Interventions included measurements annually and PRN (as needed), monitor tolerance, and passive ROM (PROM) by staff to all extremities 15 minutes BID (twice a day). Although R32 had a care plan meeting on 12/11/11, the "Care Plan Evaluation" note for "Focus of prevention and treatment of contracture" documented that "(R32's first name) has no contractures at this time." There was lack of evidence that the facility ensured that the above interventions on the care plans were being completed. Review of the annual "Range of Motion Measurements (ROMM)" document completed on 10/25/10 revealed that R32 had contracture of the right shoulder and had a decreased ROM of 80 degrees (normal range between 121-180). Recommendation by the physical therapist, E3	F 318	F318 INCREASE/PREVENT DECREASE IN RANGE OF MOTION 1. Residents R 15 and 32 remain in the center. Both residents have received updated "Range Of Motion Measurements" (ROMM). Comprehensive treatment plans have been monitored to ensure appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM. 2. In-servicing shall be completed for licensed nurses and rehabilitation staff on facility policy for ROMM and management on or before March 15, 2012. 3. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess the data and provide recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 318	Continued From page 21 was to continue ROM by nursing to bilateral shoulders. The subsequent annual "ROMM" dated 10/10/11 completed by a certified occupational therapist assistant (E4) revealed that the ROM of the right shoulder improved by 10 degrees to 90. In addition, the left shoulder flexion declined from 130 to 90 degrees and abduction declined from 125 to 90. In addition, bilateral hip extension decreased from 30 to 10 degrees. Recommendation by E4 was to continue ROM. On 1/17/12 at approximately 1 PM, the surveyor reviewed the above annual "ROMM" assessments with Director of Therapy Services, E6 who confirmed that R32 was assessed on 10/10/11 as having a decline in ROM of the left shoulder and bilateral hip. In addition, E6 confirmed that the recommendations were to continue ROM by the nursing staff. E6 indicated that the therapy department does not ensure implementation of the PROM by the nursing staff, however, the copies of the annual "ROMM" are forwarded to the nursing department and to the Medicaid Reimbursement staff, E5 to ensure that the task is entered into the facility's electronic clinical record system, Point of Care. An interview with E5 on 1/17/12 at approximately 11 AM confirmed that the certified nursing assistants were not performing PROM as evidenced by this intervention not being entered into the Point of Care. A follow-up interview 1/18/12 at 10:30 AM revealed that PROM by staff to all extremities 15 minutes BID was entered in the Point of Care after the surveyor's inquiry and conversation with E6 on 1/17/12.	F 318	LEFT BLANK INTENTIONALLY	

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F 318	Continued From page 22 On 1/18/12 at approximately 12 noon, the surveyor was provided a written statement by E6 which documented that R32's ROM was reassessed by E3 and "found that there was a discrepancy in the measurement recorded on 10/11/11" and there was no decline in the ROM. The statement further noted "Plan of correction: new measurements were taken and added to chart and task was added for ROM BID." Interview with E2 (Director of Nursing) on 1/18/12 at approximately 11:30 AM confirmed that the PROM was not being performed. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 1/18/12 at approximately 2:30 PM. 2. R15 had a care plan dated 1/5/12 for the prevention of deformities with ROM limitations. The care plan included a physical therapy ROM assessment dated 1/5/12 that documented baseline ROM measurements were taken all joints with in normal limits (WNL) except bilateral shoulder flexion 0-120 degrees, right wrist flexion 0-50 degrees bilateral wrist extention 0-20 degrees, bilateral hip extention -35 degrees bilateral hip abduction 0-20 degrees, bilateral knee extention -20 degrees, and bilateral ankle DF -5 degrees. Review of the care plan included the approach of passive ROM to all extremities by staff for 15 minutes. Review of the therapy department contracture measurement form dated 1/5/12 documented that ROM was needed and would be done by nursing.	F 318	LEFT BLANK INTENTIONALLY	

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F 318	Continued From page 23 An interview on 1/18/12 at 9:45 AM with CNA E7 and review of electronic documentation revealed that the aides were not performing ROM and there was no care area for documentation in the electronic record. An interview on 1/18/12 at 9:49 AM with E13 PT revealed that the resident was not on the therapy case load but was being seen by restorative nursing. She confirmed that nursing should be doing ROM on R15 daily. An interview with the restorative aide E21 revealed that ROM was not being done by the restorative staff but they were doing a walking program that was being documented on the electronic record. Interview with the DON E1 and ADON E15 on 1/18/12 confirmed that nursing was not aware of the therapy approach for ROM by nursing daily therefore it was not being done.	F 318	LEFT BLANK INTENTIONALLY	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	085015	A. BUILDING _____ B. WING _____	01/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 322	Continued From page 24 Based on observation, interview and review of the facility's policy and procedures it was determined that for one (R48) out of 39 sampled residents, the facility failed to provide the appropriate care and services of a PEG (percutaneous endoscopic gastrostomy) tube. The facility failed to aspirate for stomach contents to verify R48's PEG tube position and checking for residual prior to administration of medication. In addition, the facility failed to administer R48's medication via gravity through the PEG tube. Findings include: The facility's policy and procedures titled "8.2 Medication Administration: Enteral" indicated "3.7.3 Aspirate for stomach contents." In addition, "3.11 Instill at least 30 cc warm water into the tube through the syringe, allow to flow by gravity." During a medication pass observation on 1/13/12 at approximately 9:10 AM, E23 (Licensed Practical Nurse) failed to aspirate for stomach contents to verify tube position per facility policy. In addition, E23 administered the liquid form of Aspirin 81 mg. (milligram), Lasix 40 mg. and Potassium Chloride 20 meq. (millequvillant) by pushing the medication through the syringe and failed to administer the medication by gravity. An interview with E2 (Director of Nursing) on 1/13/12 at approximately 1 PM confirmed that the nurse failed to aspirate the stomach for contents prior to administration of any medication. Additionally, the nurse failed to administer medication through the PEG tube via gravity. Findings reviewed with E1 (Administrator) and E2	F 322	**F322 NURSING TREATMENT/SERVICES – RESTORE EATING SKILLS** 1. Resident R 48 remains in the facility, and continues to receive the tube feeding per physician orders and facility policy. Current residents receiving tube feedings have been assessed to determine proper tube feeding procedure is being maintained. 2. In-servicing shall be completed for licensed nursing staff on Enteral Medication Administration on or before March 15, 2012. 3. Random medication observations shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provided recommendations as necessary to obtain and maintain compliance.	2/16/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 322 F 329 SS=E	Continued From page 25 on 1/18/12 at approximately 2:30 PM. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R15 and R52) out of 39 sampled residents the facility failed to monitor and have indication for use of psychoactive medications on multiple occasions. Findings included:	F 322 F 329	**F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** 1. Resident R 15 remains in the center. The resident continues to receive medication as ordered by the physician with documentation on the MAR and behavior flow records for clinical indications for medication. The resident has been reviewed by the ICP team and the plan of care has been updated to reflect the resident's current level of care as necessary. Current residents have been reviewed for appropriate documentation necessary for administration of PRN psychotropic medications. 2. In-servicing shall be completed on or before March 15, 2012 for licensed nurses on administration of psychotropic medications and documentation. 3. Random audits shall be completed over the next 90 days to determine compliance with documentation. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/18/2012 3/15/2012 3/15/2012 3/15/2012 and ongoing

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F 329	Continued From page 26 1. R15 had a physician's order on the January 2012 plan of care for Ativan (anxiety medication) 0.5 mg twice a day as needed for anxiety. Review of the MAR documented that the Ativan was administered 8 times during the first 11 days of January (1/2, 1/3, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/11/12). There was no documentation on the MAR as to the reason for the Ativan administration or its effectiveness. Review of the Behavior Monitoring Flow Record (BMFR) for the same period of time noted no symptoms of being jittery and nervous. The resident's anxiety, behavior monitoring and use of pharmalogical interventions were not included on the care plan. Review of the nurses' notes also lacked evidence of why the resident was administered an anxiety medication on the above 8 days. An interview on 1/17/12 at 2 PM with E15 ADON confirmed there was no indication in the clinical record as to why the Ativan was administered, the BMFR was not being used properly and there was no care plan for anxiety. 2.The facility's 15.0 Behavior Monitoring Policy effective 1/1/04 and revised 5/1/11 reads "a behavior monitoring tool for customers who:exhibit behavior; are taking psychotropic medications that require monitoring." The procedure reads, "include specific diagnosis justifying the use of the drug; identify the behavior (s) to be monitored; record the number of behavior episodes, interventions tried, and the	F 329	LEFT BLANK INTENTIONALLY	

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	085016	A. BUILDING _____ B. WING _____	01/18/2012

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F 329	Continued From page 27 outcome of the interventions." R52 had a physician order dated 9/1/11 for Ativan 0.5 mg one po (by mouth) at qhs (bedtime) prn (as needed) for sleep. This order was discontinued on 12/30/11 and Ativan 0.5 mg one po q 4hr prn for anxiety/insomnia was written. The Behavior Monitoring Sheet for R52 documented she was jittery/nervous and insomnia. No behaviors were documented from January 2-16th. Review of R52's MAR (Mediation Administration Record) revealed she was administered Ativan 0.5 mg every night from January 2nd through the 16th, 2012. R52's MAR and nurses notes lacked evidence for the use this antianxiety medication and it's effectiveness. Review of R52's behavior monitoring form and MAR with E15 (ADON) on 1/17/12 at 2:15 PM confirmed the facility failed to have indication for the use Ativan or it's effectiveness.	F 329	LEFT BLANK INTENTIONALLY	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 28 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of the medication rooms in the facility on 01/17/12 and 01/18/12, it was determined that the facility failed to limit access to medications only to authorized staff. Findings include: 1. Staff member E12 physical therapist, C.N.A., was observed to take a scheduled break in the unit 2 medication room on 01/17/12 at 2:15 PM. This staff member left and reentered the room at 2:25 PM. 2. Staff members E13 and E14, maintenance	F 431	**F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** 1. The Medication rooms are secure and only licensed nursing staff shall have access. 2. In-servicing shall be completed on or before March 15, 2012 for licensed nursing staff on medication room security. 3. Random rounds shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	2/14/2012 3/15/2012 3/15/2012 3/15/2012 a-d ongoing

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F 431	Continued From page 29 supervisor, entered the unit 1 medication room at 10:22 AM on 01/18/12.	F 431	LEFT BLANK INTENTIONALLY	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center Nursing Home

DATE SURVEY COMPLETED: January 18, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from January 9, 2012 through January 18, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 107. The Stage II sample totaled thirty-nine (39) residents.	Cross reference to the CMS 2567-L survey report and POC Response for survey date completed 1/18/12, F241, F247, F248, F272, F279, F280, F309, F315, F318, F322, F329 & F431
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 1/18/12, F241, F247, F248, F272, F279, F280, F309, F315, F318, F322, F329 & F431.	

rovider's Signature [signature] Title Administrator Date Feb. 16 2012